

		FOR OHF USE					

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2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041426

Facility Name: Wynscape

Address: 2180 W. Manchester Road Wheaton 60187  
Number City Zip Code

County: DuPage

Telephone Number: (630) 665-4330 Fax # (630) 665-3181

IDPA ID Number: 363436685001

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code	501 ( c ) ( 3 )	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: Mike Kaplan Telephone Number: (312) 634-3400  
Please send copies of any desk review or audit adjustments to our accountant's address

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/00 to 6/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	SEE ACCOUNTANTS' COMPILATION REPORT
	(Date) _____	
	(Print Name and Title) _____	
	(Firm Name & Address) _____	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone) _____	(312) 634-3400 Fax # (312) 634-5518
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wynscape

# 0041426 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	12,525	17,642	9,159	39,326	8
9	SNF/PED					9
10	ICF	20,231	7,301	2	27,534	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,756	24,943	9,161	66,860	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.65%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 3/01/96

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 3/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 28 and days of care provided 8,802

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/01 Fiscal Year: 6/30/01

\* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	426,222	40,128	11,423	477,773		477,773		477,773			1
2	Food Purchase		316,907		316,907		316,907	(905)	316,002			2
3	Housekeeping	303,246	50,827	3,470	357,543		357,543		357,543			3
4	Laundry	99,433	20,094		119,527		119,527		119,527			4
5	Heat and Other Utilities			177,617	177,617		177,617		177,617			5
6	Maintenance	60,837	2,755	96,261	159,853		159,853		159,853			6
7	Other (specify):*											7
8	TOTAL General Services	889,738	430,711	288,771	1,609,220		1,609,220	(905)	1,608,315			8
	B. Health Care and Programs											
9	Medical Director			35,125	35,125		35,125		35,125			9
10	Nursing and Medical Records	3,785,925	281,000	208,382	4,275,307		4,275,307		4,275,307			10
10a	Therapy	193,011	4,522	69,937	267,470		267,470		267,470			10a
11	Activities	185,474	13,688	3,001	202,163		202,163		202,163			11
12	Social Services	56,101	14	1,777	57,892		57,892		57,892			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,220,511	299,224	318,222	4,837,957		4,837,957		4,837,957			16
	C. General Administration											
17	Administrative	88,750		503,900	592,650		592,650	225,671	818,321			17
18	Directors Fees											18
19	Professional Services			53,595	53,595		53,595	(12,070)	41,525			19
20	Dues, Fees, Subscriptions & Promotions			23,951	23,951		23,951		23,951			20
21	Clerical & General Office Expenses	258,289	36,211	16,858	311,358		311,358	(75)	311,283			21
22	Employee Benefits & Payroll Taxes			1,380,950	1,380,950		1,380,950		1,380,950			22
23	Inservice Training & Education			5,489	5,489		5,489		5,489			23
24	Travel and Seminar			6,911	6,911		6,911	(513)	6,398			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			6,092	6,092		6,092		6,092			26
27	Other (specify):*											27
28	TOTAL General Administration	347,039	36,211	1,997,746	2,380,996		2,380,996	213,013	2,594,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,457,288	766,146	2,604,739	8,828,173		8,828,173	212,108	9,040,281			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			513,923	513,923		513,923	(26,700)	487,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			218,992	218,992		218,992	(94,499)	124,493			32
33	Real Estate Taxes			(70,030)	(70,030)		(70,030)	70,030				33
34	Rent-Facility & Grounds			713	713		713		713			34
35	Rent-Equipment & Vehicles			27,545	27,545		27,545		27,545			35
36	Other (specify):*											36
37	TOTAL Ownership			691,143	691,143		691,143	(51,169)	639,974			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,245	1,245		1,245		1,245			38
39	Ancillary Service Centers		357,219	99,161	456,380		456,380		456,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,427	114,427		114,427		114,427			42
43	Other (specify):* Nonallowable costs			98,368	98,368		98,368	(98,368)				43
44	TOTAL Special Cost Centers		357,219	313,201	670,420		670,420	(98,368)	572,052			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,457,288	1,123,365	3,609,083	10,189,736		10,189,736	62,571	10,252,307			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\* See schedule of adjustments attached at end of cost report.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(87,189)	30		9
10	Interest and Other Investment Income	(94,499)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(46)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,242)	43		24
25	Fund Raising, Advertising and Promotional	(37,767)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	55,154			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (223,589)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	286,160		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 286,160		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 62,571		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wynscape Healthcare Center  
0041426  
June 30, 2001

Schedule 5A

VI. ADJUSTMENT DETAIL  
NON-ALLOWABLE EXPENSES  
LINE 29 - Other

Description	Amount	Schedule V
		Reference
Real Estate Taxes	70,030	33
Benevolence	(1,313)	43
Offset Vending Machine Income	(905)	1
Offset Other Non-patient Income	(75)	21
Disallow nonallowable legal fees	(12,070)	19
Out of state travel	<u>(513)</u>	24
Total	<u><u>55,154</u></u>	

See Accountants' Compilation Report

Wynscape

ID#0041426

Report Period Beginning:7/1/00

Ending:6/30/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

**6/30/01**

**6/30/01**

[illegible]

## Summary B

**6/30/01**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Central DuPage Health System	100			Central DuPage		
				Hospital	Winfield, IL	Hospital
				CDH Alocholic Treat	Naperville, IL	Alcoholic Treat
				Community Nursing	Naperville, IL	In-House Nursing
				Marklund Childern's	Bloomingtondale, IL	DD Child Home
				Phase II	Naperville, IL	X-Ray & Resp.
				Wyndemere Retire	Naperville, IL	Ret. Community

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	17	Management Fees	\$ 503,900	Central DuPage Health System	100.00%	\$	\$ (503,900)	1
2	V	17	Administrative Expenses		Central DuPage Health System	100.00%	729,571	729,571	2
3	V	30	Depreciation Expense		Central DuPage Health System	100.00%	60,489	60,489	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 503,900			\$ 790,060	\$ * 286,160	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Health Care Associates		x	Mortgage	\$60,195.00	01/01/00	\$ 7,029,000	\$ 6,920,222	12/31/24	0.0925	\$ 218,992	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$60,195.00		\$ 7,029,000	\$ 6,920,222			\$ 218,992	9	
	B. Non-Facility Related*												
10	Interest Income Offset										(94,499)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (94,499)	14	
15	TOTALS (line 9+line14)						\$ 7,029,000	\$ 6,920,222			\$ 124,493	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				N/A	
TOTAL REFUND \$      For 19      Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996		8	
		1997		9	
		1998		10	
		1999		11	
		2000		12	
Facility is Tax exempt as of 01/01/2000				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wynscape COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0041426

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. N/A		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,390      B. General Construction Type: Exterior Brick Frame Steel      Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility      ☐ (b) Rent from a Related Organization.      ☐ (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment      ☐ (b) Rent equipment from a Related Organization.      ☒ (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?      ☐ YES      ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: N/A      2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A      4. Dates Incurred: N/A

Nature of Costs:   
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

		1	2	3	4	
A. Land.		Use	Square Feet	Year Acquired	Cost	
1		Patient Care		2000	\$ 1,800,000	1
2						2
3		TOTALS			\$ 1,800,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	209		2000		\$ 5,726,808	\$ 143,170	40	\$ 143,170	\$	\$ 214,756	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Elevator			7/1/1996	2,468		20	123	123	555	9
10	Facility Project Number 96071 See Page 12C for Breakout			6/30/1997							10
11	General Construction Project Number 96007			6/30/1997	154,315	2,344	40	3,858	1,514	17,361	11
12	Demolition			6/30/1997	14,620		40	366	366	1,647	12
13	Construction Debris Removal			6/30/1997	18,783		40	470	470	2,115	13
14	Excavation			6/30/1997	4,356		40	109	109	491	14
15	Concrete			6/30/1997	28,710		40	718	718	3,231	15
16	Unit Masonry			6/30/1997	39,480		40	987	987	4,442	16
17	Rough Carpentry			6/30/1997	1,488		40	37	37	167	17
18	Temporary Protection Cleanup			6/30/1997	10,767		40	269	269	1,211	18
19	Wood Doors			6/30/1997	7,043		40	176	176	792	19
20	Spray on Fire Proofing			6/30/1997	11,800		40	295	295	1,328	20
21	Membrane Roofing			6/30/1997	95,011		40	2,375	2,375	10,688	21
22	Metal Door and Frames			6/30/1997	14,369		40	359	359	1,616	22
23	Wood Replacement Doors			6/30/1997	4,381		40	110	110	495	23
24	Entrances and Storefront			6/30/1997	28,398		40	710	710	3,195	24
25	Aluminum Windows			6/30/1997	127,610		40	3,190	3,190	14,355	25
26	Hardware			6/30/1997	38,367		40	959	959	4,316	26
27	Interior Glazing			6/30/1997	8,750		40	219	219	986	27
28	Drywall			6/30/1997	471,593		40	11,790	11,790	53,055	28
29	Ceramic Tile			6/30/1997	34,909		40	873	873	3,929	29
30	Resilient Flooring			6/30/1997	35,834		40	896	896	4,032	30
31	Floor Prep			6/30/1997	1,809		40	45	45	203	31
32	Painting			6/30/1997	38,007		40	950	950	4,275	32
33	Toilet and Bath Accessories			6/30/1997	20,015		40	500	500	2,250	33
34	Kitchen and Building Allowance			6/30/1997	118,968		40	2,974	2,974	13,383	34
35	Window Treatment Allowance			6/30/1997	19,238		40	481	481	2,165	35
36	Storage / Moving			6/30/1997	1,748		40	44	44	198	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Final Cleaning Allowance	6/30/1997	\$ 11,225	\$	40	\$ 281	\$ 281	\$ 1,265	37
38	Field Investigation	6/30/1997	900		40	23	23	104	38
39	Fire Protection	6/30/1997	17,701		40	443	443	1,994	39
40	Plumbing	6/30/1997	155,685		40	3,892	3,892	17,514	40
41	HVAC	6/30/1997	24,900		40	623	623	2,804	41
42	Electrical	6/30/1997	322,774		40	8,069	8,069	36,311	42
43	Fire Alarm System	6/30/1997	13,741		40	344	344	1,548	43
44	Premium Time Drywall	6/30/1997	2,366		40	59	59	266	44
45	Reconstruction Fee	6/30/1997	28,000		40	700	700	3,150	45
46	Fees to Schall Brothers	6/30/1997	72,379		40	1,809	1,809	8,141	46
47	Insurance	6/30/1997	17,277		40	432	432	1,944	47
48	Millwork	6/30/1997	61,115		40	1,528	1,528	6,877	48
49	Architect Fees	7/30/1997	150,000	30,000	5	30,000		105,000	49
50	Architectural Reimbursement	7/30/1997	10,952	2,190	5	2,190		7,666	50
51	Survey	7/30/1997	7,956	1,624	5	1,591	(33)	5,569	51
52	City Permits Fees	7/30/1997	4,886	1,243	5	977	(266)	3,420	52
53	Legal (Contract Only)	7/30/1997	6,927	1,385	5	1,385		4,848	53
54	Contingency Fees	7/30/1997	36,385	3,311	10	3,639	328	12,737	54
55	Testing Services	7/30/1997	10,864	2,173	5	2,173		7,605	55
56	Title Insurance	7/30/1997	346		1			346	56
57	Landscaping	7/30/1997	45,000	9,000	5	9,000		31,500	57
58	Fence	7/30/1997	4,287	612	7	612		2,143	58
59	Balance of Landscaping	10/23/1997	15,000	1,500	10	1,500		5,250	59
60	Seal Stripe Parking Lot	10/28/1997	2,950	493	3	492	(1)	2,950	60
61	Elevator Repairs	1/13/1998	11,000		20	550	550	1,925	61
62	Security System	2/3/1998	2,318		10	232	232	811	62
63	Elevator Repairs	7/1/1998	1,500	250	3	500	250	1,500	63
64	Elevator Repairs	11/18/1998	7,942	2,647	3	2,648	1	7,942	64
65	Gas Water Heater	11/10/1998	2,657	886	3	885	(1)	2,657	65
66	Smoke Detectors	1/11/1999	2,225	742	3	741	(1)	2,225	66
67	Elevator Repairs	1/13/1999	27,293	9,098	3	9,098		27,293	67
68	Elevator Repairs	2/8/1999	6,349	2,116	3	2,117	1	6,349	68
69	Plumbing Repairs	4/28/1999	700	233	3	234	1	700	69
70	TOTAL (lines 4 thru 69)		\$ 8,165,245	\$ 215,017		\$ 265,820	\$ 50,803	\$ 689,591	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,165,245	\$ 215,017		\$ 265,820	\$ 50,803	\$ 689,591	1
2	Rear Door Repairs	5/14/1966	2,799	933	3	933		2,799	2
3	Elevator Repairs	6/30/1999	1,600	533	3	534	1	1,600	3
4	Elevator Repairs	6/30/1999	15,078	5,026	3	5,026		15,078	4
5	Disposer & wall Heating & Cooling Units	7/1/1998	8,549	2,183	3	2,849	666	8,549	5
6	Roof Covering and Gutters	1/13/1998	4,345	724	3	724		4,345	6
7	Toilet Replacement	7/1/1999	12,397	4,132	3	4,132		6,198	7
8	Toilet Replacement	8/1/1999	1,194	398	3	398		597	8
9	Plumbing & Electric Work	7/1/1999	4,100	1,367	3	1,367		2,050	9
10	Elevator Repairs & Electric	7/1/1999	31,402	10,468	3	10,468		15,702	10
11	Sidewalk Repair	7/1/1999	1,892	631	3	631		946	11
12	Door Holders	12/31/1999	4,784	1,595	3	1,595		2,392	12
13	Electrical Panel Repair	12/31/1999	4,900	1,633	3	1,633		2,450	13
14	Nurse Call System	2/29/2000	9,083	3,028	3	3,028		4,542	14
15	Nurse Call System	2/29/2000	54,480	18,160	3	18,160		27,240	15
16	Detail of Building Improvements 06/30/2000								16
17	General Contractor Cost	6/30/2000	22,010	14,550	40	550	(14,000)	825	17
18	Demolition Cost	6/30/2000	622	15	40	15		22	18
19	Concrete Cost	6/30/2000	2,119	54	40	54		81	19
20	Masonry Cost	6/30/2000	2,223	56	40	56		84	20
21	Carpentry & Fireproofing Cost	6/30/2000	2,140	54	40	54		81	21
22	Roofing Cost	6/30/2000	4,093	102	40	102		153	22
23	Entrance Improvement	6/30/2000	1,583	40	40	40		60	23
24	Windows Cost	6/30/2000	6,191	154	40	154		231	24
25	Hardware Cost	6/30/2000	3,761	94	40	94		141	25
26	Drywall Cost	6/30/2000	18,998	476	40	476		714	26
27	Ceramic Tile & Flooring	6/30/2000	12,892	322	40	322		483	27
28	Painting & Decorating	6/30/2000	10,437	260	40	260		390	28
29	Kitchen & Millwork Improvement	6/30/2000	6,860	172	40	172		258	29
30	Plumbing & Electrical Work	6/30/2000	24,433	610	40	610		915	30
31	HVAC Work	6/30/2000	16,892	422	40	422		633	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,457,102	\$ 283,209		\$ 320,679	\$ 37,470	\$ 789,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,457,102	\$ 283,209		\$ 320,679	\$ 37,470	\$ 789,150	1
2	Prior Year Improvement to Facility Project Number 96071								2
3	General Contractor Cost	6/30/1997	145,836	17,349	40	3,646	(13,703)	20,053	3
4	Construction Insurance	6/30/1997	10,702	1,273	40	268	(1,005)	1,474	4
5	Fire Alarm System	6/30/1997	8,717	1,037	40	218	(819)	1,199	5
6	Electrical Work	6/30/1997	69,239	8,236	40	1,731	(6,505)	9,521	6
7	HVAC Improvement Work	6/30/1997	394,855	46,969	40	9,871	(37,098)	54,291	7
8	Plumbing Improvement	6/30/1997	86,233	10,258	40	2,156	(8,102)	11,858	8
9	Fire Protection Work	6/30/1997	2,096	249	40	52	(197)	286	9
10	Elevators Work	6/30/1997	1,595	190	40	40	(150)	220	10
11	Storage & Moving Cost	6/30/1997	19,125	2,275	40	478	(1,797)	2,629	11
12	Window Treatment Improvement	6/30/1997	14,142	1,682	40	354	(1,328)	1,947	12
13	Painting Work	6/30/1997	212,678	25,299	40	5,317	(19,982)	29,244	13
14	Resilient Flooring	6/30/1997	161,133	19,167	40	4,028	(15,139)	22,154	14
15	Acoustical Treatment	6/30/1997	102,956	12,247	40	2,574	(9,673)	14,157	15
16	Ceramic Tile	6/30/1997	8,396	999	40	210	(789)	1,155	16
17	Drywall	6/30/1997	11,049	1,314	40	276	(1,038)	1,518	17
18	Hardware	6/30/1997	54,460	6,478	40	1,362	(5,116)	7,491	18
19	Aluminum Windows	6/30/1997	2,616	311	40	65	(246)	358	19
20	Roofing	6/30/1997	13,942	1,658	40	349	(1,309)	1,920	20
21	Wood Door	6/30/1997	1,802	214	40	45	(169)	248	21
22	Unit Masonry	6/30/1997	7,316	870	40	183	(687)	1,007	22
23	Cast in Place Concrete	6/30/1997	13,275	1,579	40	332	(1,247)	1,826	23
24									24
25	Allocated from Central DuPage Health System					13,638	13,638		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,799,265	\$ 442,863		\$ 367,872	\$ (74,991)	\$ 973,706	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 319,196	\$ 69,454	\$ 59,513	\$ (9,941)	3-10 yrs	\$ 201,621	71
72	Current Year Purchases	15,874	1,606	1,606		3-5 yrs	1,606	72
73	Fully Depreciated Assets							73
74	Central DuPage Health Sys.			46,851	46,851			74
75	TOTALS	\$ 335,070	\$ 71,060	\$ 107,970	\$ 36,910		\$ 203,227	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1997 Ford Van Shuttle	1998	\$ 45,524	\$	\$ 11,381	\$ 11,381	4	\$ 39,315	76
77										77
78										78
79										79
80	TOTALS			\$ 45,524	\$	\$ 11,381	\$ 11,381		\$ 39,315	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,979,859	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 513,923	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 487,223	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (26,700)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,216,248	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Building Improvements	\$ 995,917	92
93			93
94			94
95		\$ 995,917	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Public Storage			713			5
6								6
7	TOTAL				\$ 713			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease N/A.
9. Option to Buy: YESNO Terms: N/A\*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$ 27,545 Description: Copy Machine \$ 18,739, Mattress \$ 4,810, Postage Meter \$ 414, Pumps \$ 3,582  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning N/A  
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides  
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	L. 10A C 1,2,&3	300	hrs	\$ 9,543		\$	168	300	\$ 9,711	1	
2	Licensed Speech and Language Development Therapist	L. 10A C. 1	1444	hrs	46,747	5		215	1,449	46,962	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	L 10A C 1,2,&3	3904	hrs	136,721	42		1,755	4,354	3,946	142,830	4
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	L. 39 C 2		# of prescripts				357,219		357,219	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): See Schedule 16A							167,128		167,128	13	
14	TOTAL				\$ 193,011	47	\$	169,098	\$ 361,741	5,695	\$ 723,850	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

SERVICES	SCHEDULE V	UNITS OF	STAFF	OUTSIDER PRACTIONER (OTHER THAN CONSULTANT)		SUPPLIES (ACTUAL OR ALLOCATED)	TOTAL UNITS (COL 2+4)	TOTAL COST (COL 3+5+6)
	LINE & COLUMN REFERENCE							
		SERVICE	COST	UNITS	COST			
IV THERAPY	L. 10a , C. 3				67,967	0	0	67,967
X-RAY SERVICES	L. 39 , C. 3				74,399	0	0	74,399
LABORATORY SERVICES	L. 39 , C. 3				24,762	0	0	24,762
TOTAL			<u>0</u>		<u>167,128</u>	<u>0</u>	<u>0</u>	<u>167,128</u>

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 778,059	\$ 778,059	1
2	Cash-Patient Deposits	25,537	25,537	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,036 )	1,196,811	1,196,811	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,666	110,666	6
7	Other Prepaid Expenses	18,314	18,314	7
8	Accounts Receivable (owners or related parties)	189,462	189,462	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,318,849	\$ 2,318,849	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	492,793	492,793	12
13	Land	1,800,000	1,800,000	13
14	Buildings, at Historical Cost	11,090,788	9,799,265	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	382,435	380,594	16
17	Accumulated Depreciation (book methods)	(1,413,029)	(1,216,248)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	141,297	141,297	19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	995,917	995,917	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,490,201	\$ 12,393,618	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,809,050	\$ 14,712,467	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 127,661	\$ 127,661	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,030	254,030	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17C	1,030,657	1,030,657	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,412,348	\$ 1,412,348	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,920,222	6,920,222	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,920,222	\$ 6,920,222	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,332,570	\$ 8,332,570	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,476,480	\$ 6,379,897	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,809,050	\$ 14,712,467	48

Wynscape HealthCare Center  
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SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.  
C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Refunds / Overpayment	(3,859)	(3,859)
Accrued Benefits	192,888	192,888
Accrued Audit / Tax Services	3,800	3,800
Due to CDHS	168,185	168,185
Due to WRC	14,252	14,252
Due to CDH	447,921	447,921
Due to Other	181,853	181,853
Patient Trust Fund	25,617	25,617
<b>Total Line 36 - Other Current Liabilities(specify):</b>	<b><u>1,030,657</u></b>	<b><u>1,030,657</u></b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,018,247	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,018,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(47,359)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (47,359)	17
	B. Transfers (Itemize):		
18	Fund Balance Transfer	484,750	18
19	MKT Appr/Depr-Goldman Combined	20,842	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 505,592	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,476,480	24 *

Operating entity only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,838,688	1
2	Discounts and Allowances for all Levels	(2,480,207)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,358,481	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	861,059	6
7	Oxygen	34,709	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 895,768	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	496,737	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,304	19
20	Radiology and X-Ray	206,898	20
21	Other Medical Services	46,188	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 782,127	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	94,499	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94,499	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19E	11,502	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,502	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,142,377	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,609,220	31
32	Health Care	4,837,957	32
33	General Administration	2,380,996	33
	B. Capital Expense		
34	Ownership	691,143	34
	C. Ancillary Expense		
35	Special Cost Centers	555,993	35
36	Provider Participation Fee	114,427	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,189,736	40
41	Income before Income Taxes (line 30 minus line 40)**	(47,359)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (47,359)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity files as part of a Consolidated Return

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Wynscape Healthcare Center  
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See Accountants' Compilation Report  
Schedule 19E

XVII. INCOME STATEMENT  
Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Vending Machine Income	905
Other Income	75
Donations Used for Operations	1,945
Other Revenue	<u>8,577</u>
<b>Total Line 28 - Other Revenue (specify):</b>	<b><u><u>11,502</u></u></b>

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,832	2,080	\$ 59,996	\$ 28.84	1
2	Assistant Director of Nursing	1,808	2,080	48,619	23.37	2
3	Registered Nurses	36,993	39,484	1,035,560	26.23	3
4	Licensed Practical Nurses	15,611	16,725	334,869	20.02	4
5	Nurse Aides & Orderlies	123,756	132,185	1,733,147	13.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,648	5,938	193,011	32.50	7
8	Rehab/Therapy Aides	8,344	9,182	140,415	15.29	8
9	Activity Director	1,832	2,080	35,078	16.86	9
10	Activity Assistants	15,164	16,268	150,396	9.24	10
11	Social Service Workers	5,152	5,752	56,101	9.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	37,688	40,754	426,222	10.46	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,547	6,003	60,837	10.13	17
18	Housekeepers	31,188	34,140	303,246	8.88	18
19	Laundry	10,615	11,501	99,433	8.65	19
20	Administrator	1,824	2,290	88,750	38.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,869	17,355	258,289	14.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,471	3,718	54,488	14.66	31
32	Other Health Ca <u>Schedule 20A</u>	16,195	18,057	378,831	20.98	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	338,537	365,592	\$ 5,457,288 *	\$ 14.93	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	169	\$ 6,876	L. 1 C. 3	35
36	Medical Director	Monthly	35,125	L. 9 C. 3	36
37	Medical Records Consultant	55	2,023	L. 10 C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	3,001	L. 11 C. 3	44
45	Social Service Consultant	11	1,777	L. 12 C. 3	45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	266	\$ 48,802		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,590	\$ 140,283	L. 10 C. 3	50
51	Licensed Practical Nurses	1,278	41,353	L. 10 C. 3	51
52	Nurse Aides	1,220	24,723	L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	6,088	\$ 206,359		53

SEE ACCOUNTANTS' COMPILATION REPORT

Wynscape Healthcare Center  
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Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Central Supply Clerk	3,156	3,343	\$ 42,457	\$ 12.70
Nursing Administration	13,039	14,714	336374	22.86
Total Line 32 - Other	16,195	18,057	\$ 378,831	\$ 20.98

See Accountants' Compilation Report

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Janis Ormond	Administrator	0%	\$ 73,183	Workers' Compensation Insurance		\$ 138,246	IDPH License Fee		\$		
Mary Grondin	Administrator	0%	15,567	Unemployment Compensation Insurance			Advertising: Employee Recruitment		19,153		
				FICA Taxes		402,868	Health Care Worker Background Check (Indicate # of checks performed 119 )		1,427		
				Employee Health Insurance		334,215	Manuals		391		
				Employee Meals			Various Subscriptions		1,843		
				Illinois Municipal Retirement Fund (IMRF)*			Various License and Fees		1,137		
				Bonus Pay		207,025					
				Uniforms		2,579					
				Employee Physical		28,500					
				Employee Relations		7,905					
				Employee Welfare		259,612					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,750	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,380,950	TOTAL (agree to Sch. V, line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description		Amount		
Central Dupage Health System - Management Fees			\$ 503,900	N/A			Out-of-State Travel		\$		
Eliminated in Col. 7											
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 503,900				In-State Travel		1,078		
C. Professional Services											
Vendor/Payee	Type		Amount								
KPMG, LLP	Accounting		\$ 3,520								
Achieve Accreditation Consulting	Administrative Consulting		10,080								
Rehabilitation Care Consulting	Administrative Consulting		9,269								
Altschuler, Melvoin and											
Glasser LLP	Accounting		9,200								
American Express Tax and											
Business Services	Medicare Consulting		587								
Katten, Muchin & Zavis	Legal		8,869				Seminar Expense		5,320		
Fenech & Pachulski, P.C.	Legal		12,070								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 53,595	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)			

**\* Attach copy of IMRF notifications**  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

Wynscape Healthcare Center  
0041426  
June 30, 2001

Schedule 21 C

XIX. SUPPORT SCHEDULES  
PART C  
PROFESSIONAL SERVICES:

VENDOR	Amount
Total Professional Services Line 19 Column 3	53,595
Fenech & Pachulski non-allowable	(12,070)
Total Professional Services Line 19 Column 8	<u><u>41,525</u></u>

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**Facility Name & ID Number**    Wynscape

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 4 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 68,178 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,427  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Draft only attached
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	426,222	40,128	11,423	477,773	0	477,773	0	477,773
2. Food Purchase	0	316,907	0	316,907	0	316,907	-905	316,002
3. Housekeeping	303,246	50,827	3,470	357,543	0	357,543	0	357,543
4. Laundry	99,433	20,094	0	119,527	0	119,527	0	119,527
5. Heat and Other Utilities	0	0	177,617	177,617	0	177,617	0	177,617
6. Maintenance	60,837	2,755	96,261	159,853	0	159,853	0	159,853
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	889,738	430,711	288,771	1,609,220	0	1,609,220	-905	1,608,315
9. Medical Director	0	0	35,125	35,125	0	35,125	0	35,125
10. Nursing & Medical Records	3,785,925	281,000	208,382	4,275,307	0	4,275,307	0	4,275,307
10a. Therapy	193,011	4,522	69,937	267,470	0	267,470	0	267,470
11. Activities	185,474	13,688	3,001	202,163	0	202,163	0	202,163
12. Social Services	56,101	14	1,777	57,892	0	57,892	0	57,892
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,220,511	299,224	318,222	4,837,957	0	4,837,957	0	4,837,957
17. Administrative	88,750	0	503,900	592,650	0	592,650	225,671	818,321
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	53,595	53,595	0	53,595	-12,070	41,525
20. Fees, Subscriptions & Promotion	0	0	23,951	23,951	0	23,951	0	23,951
21. Clerical & General Office	258,289	36,211	16,858	311,358	0	311,358	-75	311,283
22. Employee Benefits & Payroll	0	0	1,380,950	1,380,950	0	1,380,950	0	1,380,950
23. Inservice Training & Education	0	0	5,489	5,489	0	5,489	0	5,489
24. Travel and Seminar	0	0	6,911	6,911	0	6,911	-513	6,398
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	6,092	6,092	0	6,092	0	6,092
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	347,039	36,211	1,997,746	2,380,996	0	2,380,996	213,013	2,594,009
29. Total General Administrative	5,457,288	766,146	2,604,739	8,828,173	0	8,828,173	212,108	9,040,281
30. Depreciation	0	0	513,923	513,923	0	513,923	-26,700	487,223
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	218,992	218,992	0	218,992	-94,499	124,493
33. Real Estate	0	0	-70,030	-70,030	0	-70,030	70,030	0
34. Rent - Facility & Grounds	0	0	713	713	0	713	0	713
35. Rent - Equipment & Vehicles	0	0	27,545	27,545	0	27,545	0	27,545
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	691,143	691,143	0	691,143	-51,169	639,974
38. Medically Necessary T	0	0	1,245	1,245	0	1,245	0	1,245
39. Ancillary Service Cent	0	357,219	99,161	456,380	0	456,380	0	456,380
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	114,427	114,427	0	114,427	0	114,427
43. Other (specify):*	0	0	98,368	98,368	0	98,368	-98,368	0
44. Total Special Cost Ce	0	357,219	313,201	670,420	0	670,420	-98,368	572,052
45. Grand Total	5,457,288	1,123,365	3,609,083	10,189,736	0	10,189,736	62,571	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	778,059	778,059
2. Cash - Patient Deposits	25,537	25,537
3. Accounts & Notes Recievable	1,196,811	1,196,811
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	110,666	110,666
7. Other Prepaid Expenses	18,314	18,314
8. Accounts Receivable-Owner/Related Party	189,462	189,462
9. Other (specify):	0	0
10. Total current assets	2,318,849	2,318,849
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	492,793	492,793
13. Land	1,800,000	1,800,000
14. Buildings, at Historical Cost	11,090,788	9,799,265
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	382,435	380,594
17. Accumulated Depreciation (book methods)	-1,413,029	-1,216,248
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	141,297	141,297
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	995,917	995,917
23. other (specify):	0	0
24. Total Long-Term Assets	13,490,201	12,393,618
25. Total Assets	15,809,050	14,712,467
CURRENT LIABILITIES		
26. Accounts Payable	127,661	127,661
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	254,030	254,030
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,030,657	1,030,657
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,412,348	1,412,348
LONG TERM LIABILITES		
39.Long-Term Notes Payable	6,920,222	6,920,222
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	6,920,222	6,920,222
46.Total Liabilities	8,332,570	8,332,570
47.Total Equity	7,476,480	6,379,897
48.Total Liabilities and Equity	15,809,050	14,712,467

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,838,688
2. Discounts and Allowances for all Levels	-2,480,207
Subtotal - Inpatient Care	8,358,481
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	861,059
7. Oxygen	34,709
Subtotal - Ancillary Revenue	895,768
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	496,737
18. Sale of Supplies to Non-Patients	0
19. Laboratory	32,304
20. Radiologyand X-Ray	206,898
21. Other Medical Services	46,188
22. Laundry	0
Subtotal - Other Operating Revenue	782,127
24. Contributions	0
25. Interest and Other Investments Income	94,499
Subtotal - Non-Operating Revenue	94,499
27. Other Revenue (specify):	11,502
28. Other Revenue (specify):	0
Subtotal - Other Revenue	11,502
30. Total Revenue	10,142,377
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	7,392,761
42. Income Taxes	0
43. Net Income or Loss for the Year	7,392,761

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under \*\*, you must write in any comments

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RECONCILIATION REPORT

Wynscape

04:36 PM 11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	62,571	equal to	62,571	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	124,493	equal to	124,493	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	487,223	equal to	487,223	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	713	equal to	713	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	27,545	equal to	27,545	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	193,011	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	199,503	equal to	267,470	-67,967	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	361,741	equal to	361,741	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,609,220	equal to	1,609,220	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,837,957	equal to	4,837,957	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,380,996	equal to	2,380,996	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	691,143	equal to	691,143	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	555,993	equal to	555,993	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	114,427	equal to	114,427	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,266,679	equal to	3,785,925	-519,246	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	193,011	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	185,474	equal to	185,474	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	56,101	equal to	56,101	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	426,222	equal to	426,222	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	60,837	equal to	60,837	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	303,246	equal to	303,246	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	99,433	equal to	99,433	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,750	equal to	88,750	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	258,289	equal to	258,289	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,457,288	equal to	5,457,288	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	6,876	< or = to	11,423	-4,547		Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	35,125	< or = to	35,125	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	208,382	< or = to	208,382	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,001	< or = to	3,001	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,777	< or = to	1,777	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	88,750	equal to	88,750	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	503,900	equal to	503,900	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	53,595	equal to	53,595	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,380,950	equal to	1,380,950	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	23,951	equal to	23,951	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,398	equal to	6,398	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	114,427	equal to	114,427	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,802	equal to	9,159	-357	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	286,160	equal to	286,160	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	6,920,222	equal to	6,920,222	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	1,800,000	equal to	1,800,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	9,799,265	equal to	9,799,265	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	380,594	equal to	380,594	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,216,248	equal to	1,216,248	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	7,476,480	equal to	7,476,480	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-47,359	equal to	-47,359	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	15,809,050	equal to	15,809,050	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1